LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH / REVENUE MANAGEMENT DIVISION

RMD Bulletin

Knowledge is power…

OTHER HEALTH COVERAGE (OHC) INSURANCE BILLING

WHAT YOU NEED TO KNOW!

It is mandated by the State of California that every Los Angeles County Department of Mental Health (DMH) directly operated and contract provider bill private insurance companies for services rendered to their beneficiaries (with the exception of AB3632 clients).

- *Information regarding the policy for AB3632 clients is available on the Integrated System (IS) News Bulletin #26 at the following address: http://dmh.lacounty.info/hipaa/downloads/ISNews026_AB3632_and_Medi-Cal.pdf*

WHAT DOES THIS MEAN?

As the Revenue Management Division (RMD) began reviewing the claims appearing on the Error Correction Report (ECR) it became evident that providers were not billing other health coverage (OHC) before billing Medi-Cal. Prior to the implementation of the ECR, Medi-Cal would routinely deny these claims, resulting in lost Medi-Cal revenue. Further investigation alerted us that providers were also not billing OHC when it was identified for clients without Medi-Cal.

Every provider is required to identify all third party billing resources for each client and bill accordingly for the services provided to their clients.

WHAT SHOULD YOU DO?

- During the financial screening interview, the provider is to obtain complete and accurate billing information on each client/payor.
- It is imperative that all third party billing sources are identified and providers are to ensure that benefits are maximized.
- All charges are to be billed within 30 days of service.
- In the event a client does not want their insurance company billed, or refuses to release information, they must accept liability for, and pay full cost of care.
- OHC is to be billed before the claim is submitted for Medi-Cal reimbursement.

- When confirming Medi-Cal eligibility, be sure to check the eligibility message that is returned to identify OHC prior to billing Medi-Cal. A sample printout, with the OHC portion in bold, is shown below:

> LAST NAME: ROBERTS. EVC #: 1111AAAAAA. CNTY CODE: 19. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/NO SOC/SPEND DOWN. **OTHER HEALTH INSURANCE COV UNDER CODE B. CARRIER NAME: ACME HEALTHCARE. COV: IOMPVL.**

MORE INFORMATION!

- *Prepaid health care plans are identified as Health Maintenance Organizations (HMO), Prepaid Health Plans (PHP), Managed Care Plans (MCP), Primary Care Physician Plans (PCPP), and Primary Care Case Management (PCCM).*
- *"Medically necessary" describes an emergent situation requiring immediate treatment. A service is "medically necessary" when it is reasonable and necessary to prevent significant illness or to alleviate severe pain. (California Welfare and Institutions Code Section 14059.5)*

Providers are encouraged to review each policy related to prepaid health care plans for more information. Each policy identified below is available through the DMH website at the following address: http://dmhweb/dmhpolicy/

DMH Policy/Procedure 401.6 **Medi-Cal** Prepaid Health Plan Treatment and Billing

Medi-Cal prepaid health care plans are capitated plans that have been paid in advance by the government to provide physical health and mental health services. Short-Doyle/Medi-Cal (SD/MC) providers are authorized to provide the mental health services component to Medi-Cal PHP members when the member meets the definition of medical necessity. Claiming for services provided to Medi-Cal PHP members is completed through the IS in the same manner as a provider would claim services for a Medi-Cal eligible beneficiary.

DMH Policy/Procedure 401.7 **Medicare** Prepaid Health Care Treatment and Billing

Medicare prepaid health care plans are capitated plans which have been paid to provide physical health and mental health services. If Medicare prepaid health care plan beneficiaries present themselves at a DMH directly operated clinic or contract agency, the beneficiaries should be advised that their health care plan is responsible for managing their care. These plans allow for treatment of covered services outside the plan, only for "medically necessary" treatment, with **prior authorization** from the prepaid health care plan, or when the client chooses to personally pay for the full cost of treatment. Except in cases deemed "medically necessary," members should be

referred back to their respective plans unless the prepaid health care plan or the client, as appropriate, is willing to pay for the full cost of the care.

- When a Medicare prepaid health care plan denies authorization, and the consumer chooses to use the services of the Department of Mental Health or their contract providers, the consumer is responsible for the full cost of care.

DMH Policy/Procedure 401.8 **Private** Prepaid Health Care Treatment and Billing

Private prepaid health care plans are capitated plans that have been paid to provide physical health and mental health services. If private prepaid health plan members present themselves at a DMH directly operated clinic or contract agency, the members should be advised that their health care plan is responsible for managing their care. These plans allow for treatment of covered services outside the plan, only for "medically necessary" treatment, with **prior authorization** from the prepaid health care plan, or when the client chooses to personally pay for the full cost of treatment. Except in cases deemed "medically necessary," members should be referred back to their respective plans unless the prepaid health care plan or the client, as appropriate, is willing to pay for the full cost of the care.

- When a private prepaid health care plan denies authorization and the consumer chooses to use the services of the Department of Mental Health or their contract providers, the consumer is responsible for the full cost of care.
- When a private prepaid health care plan indicates that consumers have exhausted their mental health care benefits, this must be documented, in writing, by the prepaid health care plan. Once documentation is received, the members may be treated and charged the Uniform Method for Determining Ability to Pay (UMDAP) liability amount. Once additional benefits become available, usually the following January, consumers are to be referred back to their HMO/PHP.

AUTHORITY

Pursuant to the requirements of Section 10025 of the California Welfare and Institutions Code (WIC), all directly operated providers and contract agencies have the responsibility for billing all third party payors to ensure that the State shall not reimburse the provider for services when the client was entitled to benefits through a third party reimbursement source. In addition, Section 5872 of the WIC states, "In order to offset the cost of services, participating counties shall collect reimbursement for services from the following sources:

(a) Fees paid by families, which shall be the same as patient fees established pursuant to Section 5718.
(b) Fees paid by private or public third-party payers.
(c) Categorical funds from sources established in state or federal law, for which persons with mental disorders are eligible."

If you have any questions or require further information, please do not hesitate to contact RMD at (213) 639-6326 or via e-mail at RevenueManagement@lacdmh.org.